Ombudsman in Action

The Ombudsman takes action on a complaint when it has determined that action is necessary to avert or correct a harmful oversight or avoidable mistake by the Department of Social and Health Services (DSHS) or another agency.

If the Ombudsman concludes that DSHS or another agency is acting in a manner that is outside of the agency's authority or clearly unreasonable, and the act could result in foreseeable harm to a child or parent, the Ombudsman intervenes by persuading the agency to correct the problem. The office induces corrective action by sharing its investigation findings and analyses with supervisors and higher-level agency officials.

Frequently, a concern is resolved before corrective action is necessary. In these cases, the Ombudsman actively facilitates resolution by ensuring that critical information is obtained and considered by the agency and facilitating communication among the people involved.

The Ombudsman is often successful in resolving legitimate concerns by working with agencies to:

- Induce corrective action
- Facilitate resolution
- Avoid errors and conduct better practice
- Prevent future mistakes

In some cases, the Ombudsman finds that the agency's actions are not in clear violation of law or policy, but rather is poor practice. When the complaint involves a current action, the Ombudsman intervenes to assure better practice. And when the complaint involves a past action, the Ombudsman documents the issue and brings it to the attention of the agency.

On occasion, an agency error is brought to the Ombudsman's attention after the fact, and corrective action is not possible. When this occurs, the Ombudsman brings the error to the attention of high-level agency officials, so they can take steps to prevent such incidents from recurring in the future.

The following sections provide brief descriptions of complaints in which the Ombudsman induced corrective action, facilitated resolution, or prevented future mistakes in the last reporting period. It illustrates how the office works to help DSHS avert and correct avoidable errors.

Inducing Corrective Action

When necessary, the Ombudsman induces DSHS or another agency to correct a mistake by sharing its investigation findings and analyses with supervisors and higher-level agency officials.

COMPLAINT ISSUE: CHILD SAFETY FROM ABUSE

Finding: CPS[1] failed to convene a Child Protection Team (CPT) meeting regarding the case plan for a three-year-old non-dependent child who had been physically abused by his parent's paramour. Policy requires that a CPT be consulted in cases where a subject child is under age six and the risk level is assessed as moderately high or high, or when there is disagreement among the professionals involved regarding the case plan. All of these factors were present in this case (the physician disagreed with the plan to return the child home).

Outcome: The Ombudsman requested that CPS convene a CPT, which it did. The CPT recommended the child remain in the home with a number of additional safeguards. The parent signed a voluntary service agreement with all recommended services, as well as a comprehensive safety plan.

Finding: CPS failed to investigate allegations of medical neglect and physical abuse of two children, ages one and two, one of which was developmentally delayed and had medical problems. The most recent high-risk referral, from a medical professional, reported suspected non-accidental injury to the two-year-old (a broken leg). Because of high workload, CPS had waived the procedural requirement for the worker to investigate the referral within ten workdays. When the agency attempted to make contact with the family, they had moved to another region of the state. The referral was not forwarded to that region for investigation based upon the CPS supervisor's premature conclusion that abuse had already been ruled out as a cause of the injury. The Ombudsman found this to be unreasonable given the seriousness of the abuse allegations, the family's history, and the additional medical information obtained by the Ombudsman's investigation.

Outcome: The Ombudsman contacted CPS who agreed to forward the referral to the new region. The referral was investigated, and the family was provided with needed services, including family preservation services, public health nursing, and day care services.

Finding: CPS failed to take sufficient action to protect two non-dependent children, ages one and three, from physical abuse by their father. The safety plan established by CPS allowed the father to remain in the home with only supervised contact with the children, to be enforced by the mother. This was unreasonable, given the parents' initial untruthful explanation regarding the three-year-old's injury, the fact that the mother was protective of the father and would not agree to have him temporarily leave the home, and a previous report of physical abuse in another state.

Outcome: The Ombudsman discussed these concerns with the Regional Administrator, and CPS strengthened the safety plan by requiring a neutral third party to live in the home and monitor the father's contact with the children. CPS also obtained out-of-state CPS records on the family, a case review by a child abuse medical expert, parenting/psychological evaluations on both parents, and an anger management evaluation of the father. Later, during an unannounced home visit, CPS found the father in violation of the safety plan. A dependency was filed and the children were removed.

Finding: CPS failed to thoroughly assess the risk of harm to a pair of five-month-old non-dependent twins, when returning them to the care of their parents after a voluntary placement with relatives. One of the infants had incurred serious physical injuries suspicious for abuse. At a CPT meeting held to assist in deciding whether to return the infants to their parents, medical reports on both infants were presented. The CPT recommended returning the children home. However, in reviewing the medical reports, the Ombudsman found that there were concerning findings on the skeletal survey of the non-injured infant. In addition,

[1]Abbreviations used for agency divisions/sections: AAG=Assistant Attorney General, CA=Children's Administration, DCFS=Division of Children & Family Services, CPS=Child Protective Services, CWS=Child Welfare Services, FRS=Family Reconciliation Services, DLR=Division of Licensed Resources, OFCL=Office of Foster Care Licensing, CPT=Child Protection Team. Note that DLR has its own CPS units and those units are referred to as DLR/CPS.

Inducing Corrective Action *(continued)*

the relatives with whom the infants were placed had not been invited to share information with the CPT, as required by policy.

Outcome: The Ombudsman contacted CPS and found that none of the CPT members had read the medical reports, and the concerning medical findings regarding the other infant had not been brought to their attention. CPS agreed to convene another meeting to address this new information, and allow the relative caregiver to present her observations of the infants and parents to the team. The CPT recommended filing a dependency, which the agency did, and the children were placed with the protective parent while the parent suspected of abuse was allowed only supervised contact with the infants.

Finding: CPS failed to document the whereabouts and safety of a twelve-year-old non-dependent child who was listed along with his older sibling as an alleged victim of physical and emotional abuse. The child had not been interviewed as part of the CPS investigation, because the family court had placed him with his non-custodial parent out-of-state.

Outcome: The Ombudsman contacted the CPS supervisor pointing out the lack of documentation regarding the agency's work to verify that the child was in a safe environment, and to explain why he had not been interviewed. The supervisor agreed to correct the summary records.

COMPLAINT ISSUE: CHILD SAFETY FROM NEGLECT

Finding: CPS failed to screen in for investigation, a referral alleging neglect and emotional abuse of a non-dependent nine-year-old child, secondary to her parent's untreated mental illness. Instead, it was referred to the Alternative Response System (ARS) for provision of prevention services to the family.

Outcome: The Ombudsman contacted the CPS intake supervisor expressing concerns that given the parent's unwillingness to receive treatment for her mental illness and the five CPS referrals received in the last year, the child appeared to be at greater risk than was appropriate for services available through ARS. The supervisor agreed and assigned the referral for investigation. Finding the parent's capacity to care for the child seriously compromised, CPS facilitated a voluntary placement of the child with a relative.

Finding: CPS failed to adequately investigate allegations of neglect of a non-dependent infant and closed its case without services in place to assure the child's health and safety. The CPS investigation was compromised by professional misconduct on the part of the caseworker.

Outcome: The Ombudsman contacted the Regional Administrator and a new CPS referral was generated. A thorough investigation was conducted, and services provided to the family, including monitoring of the infant's safety. The Ombudsman verified that the agency was conducting an internal investigation into the caseworker's misconduct. The caseworker subsequently left the agency.

Finding: CPS failed to screen in for investigation a referral alleging that two children, ages one and two, were being exposed to methamphetamine use by a parent, and that the children appeared to be suffering symptoms of exposure to the drug. The referral was screened as "information only" as the exact location of the family was unclear. The referent had, however, indicated that the family might be staying at a local shelter.

Outcome: The Ombudsman requested a review of the screening decision, and following this, the referral was screened in for investigation. CPS began efforts to locate the family and assess the children's safety, enlisting the assistance of law enforcement. The family was located and the children's safety was addressed.

Finding: CPS failed to investigate referrals alleging neglect of a nine-year-old developmentally disabled child by the parents, due to the uncertain location of the family. The Ombudsman found the decision to screen the referrals as "information only" unreasonable, in light of the fact that the parents had been banned from homeless shelters due to chronic alcohol use, the child was not attending school, had been living in sub-standard, transient conditions over an extended period, and had reportedly lost weight.

Inducing Corrective Action *(continued)*

Outcome: The Ombudsman requested that CPS review the recent and prior referrals on the family. Based on this review, CPS agreed to make efforts to locate the family, enlisting the assistance of law enforcement. The police located the family, and the child was taken into protective custody. CPS entered into a voluntary placement agreement with the parents, the child was placed in temporary foster care, and the parents were assisted with services.

Finding: CPS failed to provide the family of an eight-year-old child with special needs with appropriate services to assist in caring for the child safely and protecting his ten-year-old sibling from harm. The child had significant mental health problems, and engaged in behaviors endangering himself and others. The parent was clearly overwhelmed and unable to protect the children's health and safety.

Outcome: The Ombudsman discussed these concerns with the Regional Administrator. As a result, the agency entered into a voluntary placement agreement with the parent, whereby the child was placed in therapeutic foster care and provided with mental health treatment, and additional services provided to the family with the goal of returning the child home.

Finding: CPS failed to file a dependency in a timely manner to protect a non-dependent twelve-year-old child from medical neglect by her custodial parent. The child's medical provider had reported the neglect to CPS, stating that the consequences could be life threatening. CPS delayed in filing a dependency to allow the non-custodial parent to petition for custody through the family court. This delay resulted in the child remaining in hospital longer than medically necessary, and provided no legal restraint on the custodial parent removing the child from the hospital and subjecting her to further medical neglect.

Outcome: The Ombudsman requested a review of the case by the Area Administrator. As a result, the administrator directed CPS to file a dependency if the non-custodial parent had not obtained custody within a tight deadline. When this had not occurred, CPS promptly filed for dependency on this date.

Finding: CPS failed to screen in for investigation, allegations of neglect regarding three non-dependent children ages nine, seven and three years old. Referral information included ongoing domestic violence and substance abuse by the parents, as well as screaming at and harsh treatment of the children.

Outcome: OFCO requested that CPS review the screening decision in light of several previous referrals reporting similar allegations, and the parents' failure to engage in services. This resulted in CPS screening the referral in for investigation, and subsequently offering services and providing other assistance to the family.

COMPLAINT ISSUE: DEPENDENT CHILD SAFETY IN OUT-OF-HOME CARE

Finding: DLR failed to require a foster parent with multiple reports of suspected sexual abuse of foster children, to undergo a sexual deviancy evaluation.

Outcome: The Ombudsman recommended to DLR that an evaluation be obtained, based on the numerous referrals (17) and sexualized behaviors reported in a number of foster children that had been placed in this home. DLR requested an evaluation, but the foster parent refused to comply. DLR removed the foster children in the home and planned to revoke the foster care license. The Ombudsman also requested that CPS provide law enforcement with information regarding the history of referrals received on this foster parent, to aid their investigation.

Finding: CPS delayed in checking on the safety of a dependent four-month-old infant in a "responsible adult placement" under condition that all parent-child contact be supervised, as the parent had serious mental health and substance abuse problems requiring treatment. CPS began receiving calls that the infant was being left alone with the parent, and that they were missing important medical appointments. Attempts to reach the "responsible adult" to check on the child's safety were unsuccessful.

Outcome: The Ombudsman requested that a child welfare check be done on

Inducing Corrective Action *(continued)*

the home as soon as possible. Two days later this had not been done, and the Ombudsman again requested this urgently. The safety of the child was only verified four days later. The Ombudsman questioned the appropriateness of this placement since the signed safety agreement was being frequently violated. CPS agreed, and filed a motion in court requesting a change of placement, but this was not granted. Two months later, after the police were called to the home because the parent (who had been left alone with the child) was wielding a knife and threatening to kill herself and the child, the child was taken into protective custody and placed with a suitable relative.

Finding: CWS failed to report to CPS concerns it had regarding the safety of a foster home, as required by law and policy.

Outcome: The Ombudsman reported these concerns and they were investigated by DLR/CPS and OFCL. The foster home was found to be violating several licensing requirements. OFCL took corrective action with the foster parents, and educated the CWS caseworkers involved regarding the violations that should have been reported.

Finding: CWS failed to follow CPS recommendations that a thirteen-year-old dependent child be removed from a relative placement after a "founded" finding for physical abuse and neglect of the child. Although CWS planned to move the child within thirty days, it had no plan for increased monitoring of the child in the home or other safeguards, despite ongoing concerns about further possible maltreatment.

Outcome: The Ombudsman asked the Regional Administrator to review the case, who found the existing case plan to be unacceptable. A safety agreement was immediately drafted and signed by the relative, including close monitoring of the child by service providers. The child was moved two days later.

Finding: CWS failed to follow the recommendations of a Child Protection Team to remove a seventeen-month old dependent child from the care of relatives with a history (past and current) of domestic violence.

Outcome: The Ombudsman urged CWS to obtain law enforcement records on the family. The agency found that the family had not provided accurate information when they were initially considered for placement of the child. The child was removed from the home and placed in a safe environment.

COMPLAINT ISSUE: SAFETY OF ADOLESCENTS

Finding: CPS planned to allow a 17-year-old non-dependent disabled youth to return to the care of a relative caregiver from a voluntary placement arranged by the Division of Developmental Disabilities (DDD), despite a long history of referrals reporting alleged abuse and neglect, and concerns of ongoing abuse of the youth in that home (37 referrals between 1991 and 2005).

Outcome: The Ombudsman requested that CPS review the family's history. Following this review, CPS concluded that the youth should not return to the relative's home. CPS and DDD cooperated in seeking an alternative voluntary placement for the youth.

Finding: Family Reconciliation Services failed to address allegations of physical abuse of a 16-year-old youth by her parent when assessing the youth for needed services. The youth was in a shelter, having run away from home and expressing fear of returning due to alleged physical abuse. FRS informed the youth that she had to return home.

Outcome: The Ombudsman contacted the FRS supervisor, who agreed that the concerns about physical abuse had not been adequately assessed. The case was reassigned, and further assessment revealed a need for out-of-home placement and services to protect the youth and assist the family.

Finding: CPS planned to return a 12-year-old non-dependent child to a relative caregiver who had failed to protect the child from severe physical abuse by a parent in the past, despite the child's expressed fears about returning, and statements that she would run away.

Outcome: The Ombudsman asked CPS to review the decision to return the child.

Inducing Corrective Action *(continued)*

CPS decided that further out-of-home placement was warranted to protect the child and to provide further therapeutic services, with the goal of returning the child once the relative was able to provide a safe environment.

Finding: During the course of assessing a family for services, FRS failed to report to CPS allegations of physical abuse of a fourteen–year-old non-dependent youth by her adoptive parent. Additionally, CWS had failed to obtain a federal criminal background check on the parent at the time of the adoption home study, as required, since the parent had lived out-of-state within the last five years.

Outcome: The Ombudsman requested that FRS report the abuse allegations to CPS. A CPS investigation was conducted.

Finding: DCFS Intake failed to screen in for child welfare services, a referral from a children's residential facility regarding the recent return home, due to closure of the facility, of a fourteen-year-old, non-dependent youth who had been placed there voluntarily by his parent two years previously. The parent had had minimal contact with the youth during the previous two years, and the conditions that existed at the time of the youth's placement still existed currently, posing a substantial risk to the youth's safety and well being (i.e. presence of a sex offender in the home). Intake screened the referral as "information only".

Outcome: The Ombudsman requested that Intake review the referral to assess the apparent need for child welfare services in this case. After further review, Intake screened in the referral for child welfare assessment and services.

Finding: CPS failed to provide an appropriate placement in a timely manner for a thirteen-year-old developmentally delayed child with various behavior disorders, who could not be safely managed at home. The child was nearing the end of a 180-day placement at a psychiatric facility, arranged by CPS, but was soon to be discharged with no long-term placement identified. CPS was awaiting a decision from Children's Administration Headquarters regarding an application for co-funding of a placement between DCFS and the Division of Developmental Disabilities.

Outcome: The Ombudsman contacted CA headquarters to inquire about the status of the co-funding request, which had been made two months previously. Within days, headquarters completed its review of the case and approved the co-funding for a suitable placement.

Finding: CPS failed to screen in for investigation a referral reporting that a non-dependent sixteen-year-old youth was homeless (with the parent's whereabouts unknown) and living in an unsafe environment.

Outcome: The Ombudsman requested a review of the screening decision, resulting in the referral being screened in for investigation. CPS ultimately coordinated a substance abuse evaluation and treatment for the youth, and arranged a voluntary placement with a relative.

COMPLAINT ISSUE: HEALTH, WELL-BEING OR PERMANENCY OF DEPENDENT CHILDREN

Finding: CWS failed to follow a reasonable process for deciding an adoption placement for a one-year-old dependent child, resulting in consideration of a family for adoption of the child other than the family who already had a relationship with the child and had an approved adoption home study. Permanency was delayed for the child as a result.

Outcome: The Ombudsman requested a review of the case by the Regional Administrator, who acknowledged that correct and reasonable procedures had not been followed by the placement committee. The administrator revised procedures governing the committee as a result. At a subsequent staffing, a decision was made to place the child with the original prospective adoptive family.

Inducing Corrective Action *(continued)*

COMPLAINT ISSUE: PARENTS' RIGHTS

Finding: CWS failed to consistently provide language interpretation of meetings and written translation of documents for a non-English speaking parent receiving services, as required by law and policy.

Outcome: The Ombudsman requested that CWS ensure that interpretation and translation be provided consistently in this case henceforth, and if reasonable efforts to obtain such were unsuccessful for a particular contact, that this be documented in the record. CWS agreed to do so.

Finding: CPS disseminated an investigative report containing inaccurate information regarding a parent, to law enforcement. The neglect allegations being investigated were concluded to be unfounded.

Outcome: OFCO contacted CPS, who acknowledged the error, and agreed to re-draft and resend the report, correcting the inaccurate information.

Finding: CPS failed to investigate a referral until thirteen months after receiving it, well outside timelines required by law and policy. Furthermore, CPS reached a finding of "inconclusive" regarding the allegation of neglect, based solely upon the child no longer being available for interviewing, and the investigation therefore being incomplete.

Outcome: The Ombudsman contacted the Area and Regional Administrators to question the reasonableness of this finding given the time lapse in investigating the referral, as well as other information gathered during the investigation, which made a finding of "unfounded" more appropriate. CPS changed the finding to "unfounded".

COMPLAINT ISSUE: SERVICES TO RELATIVES

Finding: CWS denied a request for financial assistance made by the relative caregivers of an 11-year-old dependent child, who was in the hospital undergoing treatment for cancer. The relatives needed the assistance to allow them to be with the child around the clock.

Outcome: The Ombudsman asked Children's Administration headquarters to review the request after the local DCFS office cited budgetary constraints as the reason for the refusal. CA did so, and agreed to provide a monthly stipend to the family to assure optimal support for the child and decrease the financial stress the relatives were experiencing.

Facilitating Resolution

The Ombudsman frequently is able to resolve a concern before corrective action is necessary. The office accomplishes this by ensuring that critical information is obtained and considered by the agency and facilitating communication among the people involved.

COMPLAINT ISSUE: CHILD SAFETY FROM ABUSE

Finding: CPS returned a physically disabled five-year-old non-dependent child to the care of her parents following her hospitalization for burns, without services in place to assist the family in managing the child in order to avert future injuries to the child. The family had a history of neglect and excessive corporal punishment of the children.

Outcome: The Ombudsman requested that CPS obtain a review of the case by medical experts to more carefully assess possible risks to the child's safety. This review was done, and the accidental nature of the injury was confirmed. The Ombudsman also requested that the agency provide in-home services immediately, which it did.

Finding: CPS failed to screen in for investigation a referral alleging physical abuse of a three-year-old non-dependent child with a history of suspicious physical injuries. The referral was screened as "information only".

Outcome: The Ombudsman requested a review of the screening decision. As a result, the referral was screened in, however, the investigation did not follow required procedures: the CPS worker did not interview the child, nor did she observe the injury or talk to the child's doctor or other people involved with the child to verify the parent's explanation of the injuries. The Ombudsman contacted the supervisor, and although additional investigation was later done, this occurred well beyond required timelines, jeopardizing the integrity of the investigation as a result (i.e. the three-year-old was only interviewed three-and-a-half months after being injured).

Finding: CPS was not planning to respond to a second referral it received alleging that a parent was exposing her two non-dependent children, ages four and eleven, to an 18-year-old whom she knew to be a registered sex offender. The caseworker had just investigated an initial referral and found no evidence of unsupervised contact between the offender and the children. CPS planned to change the screening decision on the new referral to "information only" as it contained similar information, and close the case.

Outcome: The Ombudsman contacted the supervisor, expressing concern that the new referral indicated the parent appeared to be continuing to allow the offender into her home, and that it was unknown whether the children were having unsupervised contact with him. The supervisor agreed to have the worker inform the parent about the new CPS referral and warn her about the risks of exposing her children to this individual.

Finding: CPS failed to complete an investigation of a referral alleging physical abuse of two non-dependent children ages three and five. The case was erroneously closed due to administrative error, prior to interviewing either the children or the alleged perpetrator as required by law and policy.

Outcome: The Ombudsman requested that CPS complete the investigation. Because it was not completed until six months after the referral, the investigation was significantly compromised.

COMPLAINT ISSUE: CHILD SAFETY FROM NEGLECT

Finding: CPS delayed in investigating allegations regarding neglect of three non-dependent children, ages fourteen, ten and one, due to chronic substance abuse by their parent. There had been multiple referrals alleging the children were tired and hungry and that the ten-year-old was caring for the toddler while the parent was unconscious. CPS had not intervened effectively in response to past referrals, and eight working days had passed since the most recent referral from a community professional.

Outcome: The Ombudsman requested that CPS check on the children immediately. On the ninth working day the assigned caseworker found the children home alone, as the parent had been arrested for driving under the influence of alcohol the night before. The children were taken into protective custody and placed with a relative.

Finding: CPS failed to investigate a referral alleging neglect of a thirteen-year-old non-dependent child with mental health problems. The referral stated that the child was dirty, was not attending school nor receiving needed special services, the home was filled with garbage and clutter, and the parent was

Facilitating Resolution *(continued)*

using drugs. The assigned CPS worker found the phone disconnected and no one at home. Assuming that the family had moved, and based upon the fact that previous allegations of neglect of this child had been investigated and unfounded, CPS planned to close its case. The Ombudsman found the agency's failure to make stronger attempts to locate the family unreasonable, given the information provided in this and previous referrals.

Outcome: OFCO requested that CPS make additional attempts to locate the family, providing suggestions to assist in these efforts. CPS managed to locate the family in a motel in a different city. Although the family had left the motel by the time law enforcement arrived to conduct a child welfare check, the assigned worker sent the referral to the CPS office in the out-of-state city to which the family was believed to have moved.

COMPLAINT ISSUE: DEPENDENT CHILD SAFETY IN OUT-OF-HOME CARE

Finding: CWS increased the risk of harm to a nine-year-old dependent child by changing conditions for visits with her parent, without careful assessment. CWS failed to obtain adequate assessments of the parent's mental state and propensity for violence (which were indicated based on the parent's history) as well as a clear service plan to address these concerns, before allowing visits to occur.

Outcome: The Ombudsman contacted the Area Administrator, who directed CWS to schedule a court hearing to request a modification of the visitation plan. CWS was court-ordered to obtain additional evaluation of the parent in order for the court to decide on a suitable visitation plan.

Finding: CWS planned to move two dependent children, ages eight and ten, from their therapeutic foster home to another temporary foster care placement. The Ombudsman found the planned move to be unreasonable, given that one of the children had been abused in a former foster home, had yet to receive treatment, and was in the process of receiving a mental health assessment. The children had been doing well in this home until they were told they would be moved. The subject child had made statements of intent of self-harm.

Outcome: Although the agency's rationale for the move was not clearly unreasonable, i.e. the children had been placed in this specialized foster home temporarily, at exceptional cost, until they were stabilized, and this had been achieved, the Ombudsman expressed concerns to CWS about the harm to the children's emotional well-being that a move might cause. After further consideration, CWS agreed to maintain the children in their current placement until a permanent placement could be found.

COMPLAINT ISSUE: SAFETY OF ADOLESCENTS

Finding: CPS was not effectively intervening to protect a sixteen-year-old non-dependent youth from alleged physical abuse by her parent, and assist them with appropriate services to address family conflict and the youth's risky behaviors, including running away, substance abuse, gang affiliation, truancy and depression. The most recent CPS case had been closed. The youth was currently due for discharge from a Crisis Residential Center and did not feel safe to return home.

Outcome: The Ombudsman requested that CPS consider filing a dependency to ensure that an out-of-home placement and services were provided for the youth and family. The agency responded by filing an At Risk Youth petition in which the agency agreed to open an FRS case, offer appropriate services, and place the youth in licensed out-of-home care.

Finding: CPS failed to file for dependency on a seventeen-year-old youth who had been in foster care for over twenty months through a voluntary placement agreement with the parent. This is a violation of law, which allows for voluntary placement for up to 180 days, after which a dependency must be filed.

Outcome: The Ombudsman contacted CPS who assured it was planning to file a dependency. The Ombudsman monitored case activity until dependency was established.

Finding: CPS failed to screen in for investigation a referral alleging that a sixteen-year-old non-dependent youth was being neglected and sexually exploited by her parent. Furthermore, CPS had filed dependencies on behalf

Facilitating Resolution *(continued)*

of the youth's six younger siblings two years previously, but not for this then fourteen-year-old youth, even though the children were all living in exactly the same circumstances. The agency based this decision on the fact that the youth was involved with the juvenile justice system at the time, and its assessment that she did not need child welfare services.

Outcome: The Ombudsman requested that CPS review the screening decision. Although the CPS Intake supervisor agreed that the referral should have been screened in for investigation, the local CPS supervisor disagreed. The Ombudsman then contacted the Area Administrator, who agreed to have the siblings' CWS worker interview the youth and try to engage her in appropriate services. The youth was subsequently admitted to an in-patient substance abuse treatment center, and CWS stated it would assess her for services and/or voluntary placement upon completion of her treatment.

COMPLAINT ISSUE: HEALTH, WELL-BEING OR PERMANENCY OF DEPENDENT CHILDREN

Finding: CWS failed to obtain authorization for a seventeen-year-old dependent youth to have necessary oral surgery in a timely manner. The lengthy delay following the oral surgeon's recommendation for surgery resulted in the youth experiencing unnecessary pain and additional complications, as well as missing school as a direct consequence.

Outcome: The Ombudsman coordinated efforts to remove administrative barriers contributing to the delay, including contacting the AAG to assist in expediting necessary documentation to promptly obtain a court order authorizing dental surgery.

Finding: CWS planned to discharge a seventeen-year-old dependent youth with special needs from his group care placement when he turned eighteen. Although this plan complied with agency policy, the youth's special circumstances appeared to warrant an exception. The youth had a history of severe maltreatment and was making excellent progress in treatment, was doing very well at school, and had no other viable placement options at that time.

Outcome: The Ombudsman asked the Regional Administrator to review the case plan. As a result, CWS extended the youth's placement by six months to allow his parent, caseworker and treatment providers to find an appropriate alternative placement and develop a transition plan that would sustain his good progress.

Finding: CWS placed a five-year-old dependent child with a parent with whom the child had no prior relationship, without adequate transition and without independently assessing the parent's suitability as a placement resource, instead relying heavily on a strong recommendation from the child's guardian ad litem (GAL). CWS then failed to seek court intervention when the parent was uncooperative with the case plan. The parent did not comply with mandated health and safety visits by the caseworker, did not obtain counseling for the child, and failed to arrange contact with his two half-siblings, with whom he had previously been living since birth.

Outcome: The Ombudsman contacted the Regional Administrator expressing concerns, and as a result, stronger efforts were made to obtain additional information regarding the parent's suitability to care for the child, to provide increased monitoring of the child's progress in the home, and ensure sibling contact and regular counseling. The Ombudsman also expressed concern about an apparent conflict of interest on the part of the GAL. A new GAL was later assigned to the child.

Finding: CWS delayed in submitting a referral for intensive in-home services to support a six-year-old dependent child in her dependency guardianship placement. The resulting two-month delay in securing services was unreasonable given the recommendation of these services by a multi-disciplinary team of mental health care providers for the child, and the fact that services could have begun much sooner.

Outcome: The Ombudsman monitored the agency's implementation of the in-home services recommended by the team, until they were ultimately approved and provided.

Facilitating Resolution *(continued)*

Finding: CWS placed a fifteen-month-old dependent child with an out-of-state relative despite receiving a home study and psychological evaluation of the relative that described serious mental health problems and instability in the past. Although both of these reports recommended placement with the relative, they were brief and superficial. In contrast, a psychological evaluation of the child's parents completed by a DCFS-contracted psychologist recommended against placement with the relative, based on thorough information-gathering regarding the family's history. The child's guardian ad litem similarly recommended against the placement, listing a number of legitimate concerns in his court report.

Outcome: The Ombudsman requested that the adoptive home study on the relative that CWS planned to arrange, address the numerous questions that had been raised regarding the relative's suitability for permanent placement of the child. Before the home study could be completed, the relative experienced a serious mental health crisis causing her to be hospitalized. The child was ultimately returned to his former foster home in Washington, where he had been living since the age of two months, as an adoptive placement.

Finding: OFCL refused to grant a temporary administrative exception to policy, to allow a twelve-year-old child to join his sibling in a foster home that was already at full capacity. This appeared unreasonable, given that the subject child was living in a marginal foster home where contact with his sibling was not being supported, his sibling was doing very well in the foster home in question, the foster parents were eager to have both children in their care, and the child's guardian ad litem as well as other community professionals believed this placement to be the best option for the child.

Outcome: The Ombudsman contacted the statewide director of OFCL, who agreed to review the exception request, as agency policy allows exceptions to be made to allow siblings to be placed together. As a result, the temporary exception was granted once CWS staff presented a safety plan to ensure the safety of all the children in this foster home.

Finding: CWS planned to seek a non-relative adoptive placement for a ten-year-old dependent child, after she had to be removed from her pre-adoptive placement due to emotional abuse by the foster parents. Her grandparents, who had requested that the child be placed with them four years previously, were not selected for placement at that time due to the agency's lack of confidence that they would be able to protect the child from her abusive parent.

Outcome: The Ombudsman requested that CWS reconsider the grandparents as a permanent placement resource at this juncture, given that the child had been abused in non-relative care and wanted to live with her grandparents, and the grandparents had had minimal contact with the child's parent in the interim years. CWS agreed to reconsider the grandparents, and an updated home study resulted in a favorable assessment of their ability to provide safe care for the child. The child was permanently placed with her grandparents.

Finding: CWS failed to pick up a youth from a Crisis Residential Center (CRC) after his 5-day stay limit expired. The CRC explored family resources to no avail, and was therefore forced to keep the youth beyond the five days permitted by law. While the caseworker was in an all-day meeting on the fifth day of the youth's placement, and the CRC was in another part of the state, CWS should have made alternative arrangements to avoid this violation of state law.

Outcome: The Ombudsman contacted CWS, who picked up the youth on the sixth day and placed him elsewhere.

COMPLAINT ISSUE: PLACEMENT WITH RELATIVES

Finding: CWS planned to permanently place a dependent one-year-old child with her non-relative foster parents, even though a relative with an approved home study was available. This decision, while based on the parents' preference regarding placement for the child, was not consistent with law and policy, which gives preference to placement with a relative when possible. In addition, there

Facilitating Resolution *(continued)*

were concerns regarding the suitability of these foster parents as a permanent placement resource.

Outcome: The Ombudsman contacted the Regional Administrator, who was already reviewing this case, and provided information obtained through OFCO's investigation. The administrator determined that the child should be placed with the relative and directed CWS to implement this plan.

Finding: CWS was not planning to reconsider placing a twelve-year-old dependent child with a relative, after his planned permanent placement failed. The relative had previously been considered for placement for this child and his three siblings, but other permanent placement options were selected for all of the children at that time. The relatives had not been ruled out, however, and were still available and willing to have the child placed in their care; in addition, the child's parent wanted this to occur.

Outcome: Although the Ombudsman did not find the agency's failure to reconsider the relatives to be clearly unreasonable, given the subject child's failed permanent placement and limited placement options, the Ombudsman requested that the relatives be reconsidered for placement of this child. The agency agreed to do so, but ultimately the court ordered an alternative, non-relative placement for the child.

COMPLAINT ISSUE: FOSTER PARENT ISSUES

Finding: OFCL erroneously referred a foster parent (who was also a day care provider) for a psychological evaluation, to a psychologist whose contract with the agency had lapsed. The agency was then unable to pay the evaluator, and hence obtain the results of the evaluation, until the lapsed contract was in order. The foster parent was unable to provide either foster care or day care until a decision was made regarding her license, based on the results of the evaluation. There were administrative difficulties getting the contract reinstated, and with the goal of getting the licensing issue resolved sooner, OFCL requested that the foster parent undergo a second evaluation with another provider.

Outcome: The Ombudsman contacted OFCL to question the reasonableness of this request. OFCL agreed to make further attempts to get the contracting issue expedited to avoid a second evaluation. The contract issue was only resolved five months later. The results of the evaluation were positive and the foster parent's license was reinstated, but she had experienced a great deal of stress and lost income from her day care due to the lengthy delay in resolving the licensing issue. The agency acknowledged its error and apologized to the foster parent.

COMPLAINT ISSUE: BUREAUCRATIC ERRORS

Finding: CPS disclosed the identity of a confidential referent, to the person who was the subject of a CPS referral. Administrative staff covering for the CPS supervisor had inadvertently sent a report containing the identity of the referent, intended for law enforcement, to the subject of the referral.

Outcome: The Ombudsman informed CPS of this violation of law and policy, and CPS sent a letter of apology to the referent. The Ombudsman also ensured that CPS reviewed procedures with staff to prevent dissemination of confidential information in the future.

Assisting the Agency in Avoiding Errors and Conducting Better Practice

In some cases, the Ombudsman does not find the agency's actions to be in clear violation of law or policy, but rather to be poor practice. If the complaint involves a current action, the Ombudsman intervenes to assure better practice. If it involves a past action, the Ombudsman documents the issue and brings it to the attention of the agency on an as-needed basis.

COMPLAINT ISSUE: CHILD SAFETY FROM ABUSE

Finding: CPS failed to enter into a voluntary placement agreement (VPA) with a parent whose three non-dependent children had been taken into protective custody by law enforcement, due to allegations of physical abuse of the oldest child. The law requires that either a VPA be entered or a dependency petition filed within 72 hours of children being taken into protective custody. Instead, CPS accepted the parent's verbal consent to place the children with a relative. The parent stated that consent was given under duress.

Outcome: The Ombudsman requested that CPS enter a VPA or file a dependency, to solidify the children's placement in protective custody. The parent refused to sign a VPA, and CPS did not file a dependency. The children remained with the relative, with the parent's verbal consent, during the investigation by CPS and law enforcement, and CPS offered services to the family. The parent was later charged with assaulting the child.

Finding: CPS did not adequately protect two non-dependent children, ages three months and eighteen months, from ongoing neglect and suspected physical abuse by their parents, who had been the subject of multiple CPS referrals. The Ombudsman found the investigation of the most recent referrals, reporting a skull fracture in the eighteen-month-old, to lack thoroughness. In addition, there were no services in place to ensure the children's safety in the home.

Outcome: The Ombudsman requested that CPS take additional steps to ensure the children's safety, including review of the child's medical records by a child abuse expert and gathering further information from the police investigation, as well as a Child Protection Team (CPT) staffing of the case. CPS took these steps, and the CPT recommended that the parent be required to sign an agreement for specific services and a comprehensive safety plan in the home. The parent failed to comply with the agreement, and CPS removed the children and filed a dependency petition.

Finding: CPS failed to adequately investigate allegations of physical and emotional abuse of a three-year-old dependent child living with his parent in an in-home dependency. CPS did not interview key medical professionals who reported the suspected abuse, and did not obtain assessments available to assist in determining the cause of the child's injuries. CWS then failed to present the case to the Child Protection Team (CPT), as required by policy when deciding whether to return a child home, in cases such as this (child under age six, high risk tag assigned to case). CWS returned the child to the parent.

Outcome: The Ombudsman requested that the medical professionals involved be interviewed as part of the investigation, and that all key medical information be presented to the CPT. Although the CPT did not recommend removal of the child, the Area Administrator found the CWS caseworker to be biased in her assessment of the family, and the case was transferred to a different worker. Following closer assessment, CWS recommended to the court that the child be removed, but the court declined. Four months later, the child's day care reported serious physical abuse of the child in the home. A CPS investigation led to founded findings, and the child was placed with a relative.

Finding: CPS failed to follow required timelines regarding investigation of a referral. One month after receiving a report of suspected physical abuse of two eight- and ten-year-old non-dependent children, CPS had not yet begun its investigation. The referral had been screened in for a high standard investigation, i.e. requiring a face-to-face interview of the children within ten working days.

Outcome: When CPS received another high-risk referral from a medical professional a month after receiving the first report, it began investigating both referrals immediately. The earlier referral had not been assigned due to supervisor error.

Finding: CPS failed to take reasonable steps to ensure the safety of a five-year-old non-dependent child who was living in the custody of a parent who was facing felony charges of rape of another child. CPS delayed in investigating a referral from a community professional

Assisting Agencies... *(continued)*

concerned about the child's safety under the circumstances. The child was not seen nor interviewed until over a month later. The child did not disclose any abuse, and on this basis the agency declined to consider either an in-home safety plan or a temporary out-of-home placement during the parent's trial.

Outcome: The Ombudsman requested a review of the case by the Area Administrator. No action was taken other than CPS encouraging the non-custodial parent to file for a protection order through family court. The family court ordered placement of the child with the non-custodial parent, five months after CPS received the referral.

COMPLAINT ISSUE: CHILD SAFETY FROM NEGLECT

Finding: CPS failed to maintain a consistent case plan to protect a newborn infant from neglect in the same manner as it had protected the child's three older siblings. The mother had a history of mental health problems, and had had her parental rights terminated regarding her oldest child, age four, in another state. CWS had already filed a petition to terminate parental rights to the middle two children, ages one and two, who had severe developmental delays resulting from their chronic neglect. Prior to the birth of her fourth child, the mother and that child's father left the region in which they had been living, in order to avoid removal of the baby by CPS. Despite this history, the CPS office in the new region decided not to remove the newborn on the basis that the parents' current functioning was satisfactory.

Outcome: The Ombudsman requested a case review by the Area Administrator in the new region. Although the administrator declined to alter the case plan, CPS was directed to present the case to the CPT and invite the region with an open CPS case on the older siblings to attend. The CPT recommended intensive monitoring of the infant by CPS and various in-home service providers. Meanwhile, the parents separated and the mother began a new relationship with an individual with a criminal history and history of domestic violence. CPS then attempted to obtain a protective custody order on two occasions, with the court refusing each time. Two months later, police were called out to the home after a domestic violence incident, and based on the condition of the home, took the child into protective custody. CPS filed a dependency and placed the three-month-old infant with one of the older siblings in foster care.

Finding: CPS failed to document in a timely manner its investigations of two referrals alleging neglect of two previously dependent children, ages five and eleven, by their relative caregiver. There was no documentation in the case record for several months after the referrals were made. Policy requires completion of high standard CPS investigations, including all documentation and an investigative assessment summary, within 90 days of a referral being made. The case also was not presented to a CPT as planned.

Outcome: The Ombudsman contacted CPS to request information about what had been done regarding these investigations, in order to determine whether the children were safe. The Ombudsman also requested that the case be presented to the CPT for assistance with risk assessment. When documentation was still outstanding seven months after the referral had been received, the Ombudsman contacted the Area Administrator, and documentation was completed two days later.

Finding: CPS delayed in protecting two children, ages six and seven, from chronic neglect secondary to drug abuse and domestic violence by their parents. Although the agency arranged in-home family preservation services, this failed to alleviate the family's problems, and the service provider reported to CPS continued neglect of the children. CPS requested a child welfare check by law enforcement, who believed there were insufficient grounds (no imminent risk of harm to the children) to take the children into protective custody. The family then moved to another area of the state.

Outcome: The Ombudsman contacted CPS to express concern regarding the risks to the children in the care of their parents, and the agency's failure to intervene despite the ineffectiveness of its services in decreasing the risk of harm to the children. The Ombudsman monitored the case. When the family later returned to the area, CPS entered into a voluntary placement agreement with the parents, whereby the children were placed with

Assisting Agencies... *(continued)*

a relative while the parents received in-patient substance abuse treatment. Subsequent interviews with the children revealed their emotional difficulties as a result of their neglect.

Finding: CPS was failing to intervene to protect three non-dependent children, ages eight, twelve, and thirteen, from ongoing neglect by their parent. The parent had a history of involvement with CPS, and the children had been previously dependent, but were returned to their parent's care a year ago. CPS continued to receive referrals alleging ongoing neglect of the children, including a recent referral alleging that the thirteen-year-old was working for a registered sex offender prohibited from having contact with minors, and had accompanied this individual on a trip out-of-state. CPS intake screened this referral as alleged abuse by a third party, therefore to be referred to law enforcement for investigation.

Outcome: The Ombudsman requested a review of this screening decision, believing that the referral warranted a CPS investigation of the parent's alleged failure to protect the child. CPS did not change the screening decision but agreed to check on whether the report was referred to law enforcement, as there appeared to have been no law enforcement response. CPS also agreed to interview the youth regarding possible exploitation by the registered sex offender, since this was an open CPS case in response to previous referrals for neglect. Before the agency was able to locate the youth, however, it received a report that that the parent had gone out-of-state leaving the two younger children in the care of a drug dealer with several arrest warrants. (The thirteen-year-old had been sent by the parent to live with relatives out-of-state.) The police took the children into protective custody and CPS filed another dependency.

Finding: CPS provided to law enforcement the contact information of a relative of a seven-year-old non-dependent child, knowing that law enforcement intended placing the child there, and that this would be an inappropriate placement for the child. CPS failed to inform law enforcement that the relative was living with a drug user and had an extensive history of involvement with CPS.

Outcome: The relative subsequently contacted CPS for assistance, and the agency provided assessment and services to the child and family. The Ombudsman contacted the CPS intake worker, who agreed that in the future such requests would be forwarded to a CPS field worker who could provide any relevant information the agency had on the desired placement resource.

COMPLAINT ISSUE: DEPENDENT CHILD SAFETY IN OUT-OF-HOME CARE

Finding: DLR failed to screen in for CPS investigation a referral from a community professional who observed a foster parent "yelling and screaming" at and "beating with an open hand" two foster children ages three and four. Instead, the referral was screened as a licensing complaint (as no injury was specified) and was investigated by the licensor for alleged inappropriate use of discipline by a foster parent. The Ombudsman determined that the referral should have been screened in for investigation by DLR/CPS, given the reported serious violation of discipline policies by a foster parent, as witnessed by a community professional, and the young age of the children.

Outcome: The Ombudsman requested a review of the screening decision, but it remained screened as a licensing complaint. The OFCL supervisor agreed to have the children interviewed by the licensor. The foster parent was required to sign a discipline policy agreement and attend a parenting class.

Finding: DCFS placed an infant with an out-of-state relative, without an approved home study through the Interstate Compact on the Placement of Children, as required by law. Moreover, a home study was never done subsequent to the placement of the child.

Outcome: The child was removed from the relative three years later, after ongoing exposure to domestic violence and other family problems. The agency later discovered a criminal history of the relative's spouse. Despite the instability of this placement over the three-year placement, DCFS did not arrange for appropriate services to assist the child and family.

Assisting Agencies... *(continued)*

Finding: CWS delayed in removing two foster children, ages five and thirteen, from a foster home where lack of supervision and inadequate parenting skills on the part of the foster parents jeopardized the safety and well-being of the children, as evidenced by accidental injuries and risky behavior of the children. When the foster parents failed an adoption home study, CWS provided services to address these problems, but they were never satisfactorily corrected and CPS continued to receive referrals for neglect. These legally free children remained in this marginal placement for four years.

Outcome: The foster parents failed a second adoption home study and the children were moved to a different placement, causing adjustment problems since they had bonded with their foster parents over this long period of time. CWS acknowledged its poor practice in this case.

Finding: CPS allowed a nine-year-old dependent child to go on a ten-day visit to the home of her parent in another region of the state without assessing the parent's home or possible risks to the child. The parent had an extensive history of CPS involvement as well as untreated, ongoing substance abuse problems.

Outcome: The Ombudsman contacted the supervisor expressing concern regarding the risks to the child posed by this action. No further visits occurred while CPS gathered further information regarding the parent's current circumstances and participation in services. Based on closer assessment and the parent's lack of compliance with services, CPS decided to pursue permanent out-of-home care for the child.

COMPLAINT ISSUE: SAFETY OF ADOLESCENTS

Finding: CPS failed to protect a thirteen-year-old non-dependent child from ongoing neglect by her parent. The parent had a twelve-year history of involvement with CPS, secondary to a serious drug problem, and had recently left the state, leaving the youth in a local youth shelter, with no plan for a permanent living situation. The child was periodically leaving the shelter to roam the streets, and was associating with an adult male suspected to be grooming youths for sexual exploitation. The shelter did not have the authority to intervene in a parental or other capacity. CPS had an open case on the family, having just completed an investigation of a referral alleging neglect of this child and her three younger siblings, with a finding of "inconclusive".

Outcome: The Ombudsman requested that CPS assess the child for services and possible out-of-home placement. The agency refused, saying the case was to be closed, as the child was not interested in services or placement. CPS indicated it would respond to any new referrals with further assessment. The Ombudsman monitored the child's situation as long as her whereabouts were known. One new referral was made alleging sexual exploitation of adolescent girls by the adult male in question, but this was screened as information only due to incomplete identifying information of the alleged victims.

COMPLAINT ISSUE: HEALTH, WELL-BEING OR PERMANENCY OF DEPENDENT CHILDREN

Finding: CWS planned to move a three-year-old legally free, severely physically disabled child from his relative placement, where he had been living since infancy, to a non-relative adoptive placement, after giving the relatives an ultimatum to adopt him. The agency based its position on the financial costs to the state if the child's permanency plan was anything other than adoption, given the child's extensive medical needs. The relatives, while fully committed to caring for the child permanently, were concerned about a lack of clarity in the proposed adoption support agreement regarding their long-term financial obligations under an adoption, since they had two of their own children to consider also.

Outcome: The Ombudsman contacted the Regional Administrator expressing concern regarding the agency's plan to move this fragile child based on financial concerns rather than what was clearly in the child's best interests. The agency did not change its position. However, the court ordered a permanency plan of dependency guardianship with the relatives, which would require that they receive long term assistance in meeting the child's medical needs.

Assisting Agencies... *(continued)*

Finding: CPS failed to place a one-year-old dependent child with special medical needs in appropriate placements, resulting in her being moved to five different placements over the course of a year. Two of these placements were foster homes from which the infant had to be removed after the foster parents were found to be providing inadequate care. The Ombudsman found that the infant should not have been placed in these homes given her particular vulnerability (age and fragile medical status), in light of concerns the agency already had regarding these foster homes. This was a violation of recently established policies created to avoid multiple placements of children, following the court decision in *Braam vs. State of Washington*.

Outcome: The child was already moved to a suitable foster home with an aggressive plan for reunification with her parent when the Ombudsman received this complaint. OFCL took corrective action with regard to both foster homes in question. One is no longer licensed.

Finding: CWS failed to schedule a permanency planning court review hearing within required timelines, delaying the return of a thirteen-year-old child to her parent. The review hearing was held a month later than the timeframe allowable by law for establishing permanency for a dependent child. The Ombudsman found several violations of policy and procedure in the management of this case. The child had been placed in a non-licensed home without a court order, and the transfer of the case from one caseworker to another was not handled effectively, resulting in inadequate supervision of the child's placement and the case plan. No case activity was documented for several months (including required 90-day health and safety checks on the child), and the caseworker did not know the whereabouts of the child for approximately two months.

Outcome: The agency acknowledged that the unit handling this case had been without a supervisor for three months, and that many cases needed corrective action. A new supervisor was assigned to the unit, who provided increased monitoring and oversight of the case. After three months of monitoring by the Ombudsman, the child was placed with her parent out-of-state, and the dependency was later dismissed.

Finding: CWS managed a parent's request to dismiss a guardianship on her twelve-year-old dependent child, in an unreasonable manner. The child's dependency had been established eight years previously, due to the parent's diagnosis with an incurable mental illness, and failure to respond to substance abuse treatment. The child had been living with his guardians throughout his dependency, and had regular visitation with the parent as established by the guardianship order. The parent contacted the agency stating her desire to vacate the guardianship based on a change in her circumstances. After a meeting with the parent, the agency advised her to contact her attorney, stating it would support vacating the guardianship. The agency then left a telephone message for the guardians informing them of this development. The agency's actions were unreasonable, as it made no proper assessment of the parent's current ability to parent, or the child's current needs or wishes.

Outcome: The guardians requested a meeting with the supervisor and Area Administrator, with several positive results. A new caseworker was assigned to the case, a psychological evaluation was arranged to assess the advisability of reunification, and counseling sessions were arranged for the parent with the child's counselor to assess the same. The court appointed a guardian ad litem to independently assess the best interests of the child. The parent ultimately agreed to maintain the guardianship as being in the child's best interests.

Finding: CWS delayed in finalizing the adoption of two eight-year-old dependent siblings with special needs, for 22 months after they became legally free. The delay occurred in spite of the children having been in the care of their relatives (the prospective adoptive parents) for three years. Uncertainty over the adoption was stressful for both the children and their caregivers.

Outcome: The Ombudsman requested that the agency assist the relative in preparing the complicated paperwork necessary due the children's special needs. CWS assigned the case to an adoption worker specializing in adoption support to expedite the process, resulting in the adoption being finalized two months later.

Assisting Agencies... *(continued)*

Finding: CWS moved a ten-year-old dependent child from her therapeutic foster home to a regular foster home prematurely, without adequate transition and preparation of the new foster parents, and before the child had received adequate treatment to address her sexual abuse in her parent's home. This inadequate planning resulted in the child's new foster parents requesting that she be moved after just one day. The child was moved back to the therapeutic foster home.

Outcome: The Ombudsman expressed concern about the disruption caused to the child, and the need for effective counseling. CWS met with the therapeutic foster parent and other professionals involved with the child, to develop a case plan for effective services and eventual reunification of the child with her parent.

Finding: CWS was planning to move a two-year-old dependent child from her foster parent, with whom she had been living since the age of five months, and who wanted to adopt her. The foster parent had undergone a home study that recommended her for adoption of the child. CWS had some concerns about the foster parent's history, and wanted to place the child together with her two older siblings in another adoptive home. The child's guardian ad litem was supportive of her being adopted by her foster parent.

Outcome: The Ombudsman requested that CWS obtain additional evaluations to further assess its concerns about the foster parent and more closely assess this child's needs. Further evaluation, together with the agency's inability to find an adoptive home that would adopt all three of these children with special needs, as well as the foster parent's commitment to maintaining the child's relationship with her siblings, resulted in a recommendation for the child to be adopted by her current foster parent.

COMPLAINT ISSUE: PARENTS' RIGHTS

Finding: CPS made unfair statements questioning the integrity of a non-custodial parent's allegations regarding the treatment of his child by the custodial parent, in documentation of its investigations into several CPS referrals made by that parent. The veracity of the allegations was subsequently given credence by the family court, which granted full custody to the previously non-custodial parent.

Outcome: With the assistance of the Ombudsman, the parent contacted the CPS supervisor with a complaint. CPS acknowledged the inappropriateness of the statements in the case record, and wrote a letter of apology to the parent.

Finding: CPS failed to send a letter to parents who had been the subject of a CPS investigation, notifying them of the "founded" findings (i.e., that maltreatment had likely occurred). The parents only discovered this finding when they requested placement of a relative's child. By law, CPS is required to provide written notification to subjects of abuse investigations, regarding the findings.

Outcome: The parents requested an administrative review of the findings, and the Area Administrator concluded that the findings should have been "inconclusive" rather than "founded". A home study was done. And the child needing placement was placed with his relatives.

Finding: A CWS worker wrote inaccurate, subjective and misleading statements about prospective adoptive parents in an adoption home study.

Outcome: The Regional Administrator and Children's Administration Headquarters investigated the prospective adoptive parents' complaint and found it to be valid. CWS transferred the case to another office for a new home study. The revised home study was deemed fair and accurate by the prospective adoptive parents.

Finding: CWS suspended visits between a parent and a three-year-old dependent child, based on allegations that the parent was molesting the child during visits. The five-month suspension of visits was unreasonable, given the implausibility of the sexual abuse allegations, the fact that visits were supervised, and parent-child interactions were observed to be positive.

Outcome: The parent was asked to undergo a psychosexual evaluation, which indicated that visits could safely continue. Visits were restored after five months of no contact.

Finding: CPS developed a plan for the safety of a fifteen-year-old non-

Assisting Agencies... *(continued)*

dependent youth that stated the youth was sexually abused by her custodial parent, and incorrectly implied that parent's agreement with the plan. This was unreasonable, as the allegations of abuse were still under investigation, and the parent was not in agreement with the safety plan.

Outcome: CPS drafted a new safety plan containing accurate information. However, the non-custodial parent had already distributed the original plan, possibly damaging the custodial parent's reputation.

Finding: CWS was failing to reunite an eleven-year-old dependent child with parent, despite the parent having completed all court-ordered services and indicating no deficiencies precluding parent from caring for the child. The child was refusing to see his parent, and the agency was failing to take appropriate steps to re-establish parent-child contact.

Outcome: The Area Administrator assigned the case to a senior caseworker, to conduct a case review and make recommendations regarding reunification efforts. This resulted in a recommendation for aggressive reunification efforts, including referring the child to a new therapist. The child was successfully returned home six months later.

COMPLAINT ISSUE: PLACEMENT WITH RELATIVES

Finding: CWS failed to consider the distant relatives of a one-year-old dependent child for permanent placement, even though they were licensed foster parents in another state and had requested placement of the child at the time of the child's birth. The parents were unavailable for services aimed at reunification, and were in the process of having their parental rights terminated as to an older child.

Outcome: The Ombudsman contacted CWS and requested consideration of the relatives, even though they were not "relatives of a specified degree" as defined by state statute. A case staffing was held, resulting in a recommendation to transition the child from her foster home to her relatives. A home study of the relatives was requested only two months later, and a positive report was received another three months later. CWS was not satisfied and requested additional information. By the time this was received, the child was fifteen months old, and CWS decided to allow her to be adopted by her foster parents rather than disrupt the attachment and bonding that had by now occurred.

Finding: CWS refused to consider the relative of an eight-year-old dependent child for either placement or visits, until a year-and-a-half after he had been placed in foster care. Although the agency had concerns about the relative's history, her circumstances and suitability for placement should have been thoroughly assessed as soon as she requested placement and contact with the child. Furthermore, CWS did not pass on gifts the relative had sent for the child.

Outcome: The case was transferred to a permanency-planning unit, and the new worker promptly arranged visits, and requested specific evaluations to assess the relative's past problems, as well as a home study to assess her current circumstances.

Finding: CWS caused an unreasonable delay (almost a year) in placing a twelve-year-old dependent child with a relative, due to poor case management. The supervisor and caseworker failed to attend the child's treatment team meetings (though repeatedly invited), which could have quickly resolved the concerns they had expressed about placing the child with the relative. Agency staff also delayed in setting up meetings they had requested to review the safety plan proposed by the child's therapist to address these concerns, including canceling one of the meetings at short notice. The child experienced four different placements in the interim.

Outcome: The child was ultimately placed with the relative, prior to the Ombudsman receiving this complaint. The Ombudsman noted that the Regional Administrator was aware of management problems in this DCFS office, and was in the process of addressing these problems in order to improve case management.

Finding: CWS removed three dependent children, ages nine, five and two, from their relative placement where they had been living for almost two years, without any notice to the relative and in a traumatic manner, after receiving

Assisting Agencies... *(continued)*

an allegation of a foster care licensing violation by the relatives (who were licensed foster parents). A subsequent CPS investigation into an allegation of physical abuse of the oldest child by one of the relatives resulted in unfounded findings. The children were not allowed contact with their relatives for three months after they were moved. This was particularly traumatic for the two younger children.

Outcome: The Ombudsman discussed numerous concerns regarding case management with the Area Administrator, who began actively overseeing the case and identifying training needs on the part of the caseworker and supervisor. After consultation with the children's therapists, visits with their relatives were arranged. The administrator acknowledged that the emergent and traumatic removal of the children could have been avoided by more thorough information gathering by CWS. All available relatives were thoroughly assessed for adoption of the children.

COMPLAINT ISSUE: FOSTER PARENT ISSUES

Finding: CWS provided inadequate assistance to a foster parent needing respite care for her fourteen-year-old foster child with special needs. The foster parent had been requesting assistance from the agency for the past five months, unsuccessfully. Although the agency provided her with a list of respite care providers, she was unable to access care from any of them. The youth had already experienced eighteen different placements, including a failed residential treatment program. The foster parent stated that if she did not obtain respite care, she would be unable to continue caring for the youth.

Outcome: While the agency did not violate existing law or policy by placing responsibility for securing respite care upon the foster parent, the exceptional circumstances in this case warranted additional assistance from the agency. The Ombudsman has noted that the system for accessing respite care appears unclear and unreliable.

Finding: CWS failed to effectively communicate with the foster parents of a three-year-old dependent child regarding the child's case plan, resulting in a poor working relationship with the foster parents, who had a history of providing exemplary care of foster children for the agency.

Outcome: The caseworker's poor communication with the foster parents (as witnessed by others) resulted in increasing conflict over the case plan, culminating in the foster parents requesting removal of the child from their care. Although the child was ultimately placed back with them in an adoptive placement, the family decided to cease providing foster care services for the agency due to their negative experience with this caseworker.

Preventing Future Mistakes

When corrective action is not possible, the Ombudsman brings the error to the attention of high-level agency officials, so they can take steps to prevent such mistakes from recurring in the future.

COMPLAINT ISSUE: CHILD SAFETY FROM ABUSE

Finding: CPS failed to follow required procedures regarding child sexual abuse investigation, in an investigation involving allegations of abuse of a five-year-old child by her non-custodial parent during visits. CPS failed to follow established protocol of contacting the local multi-disciplinary team set up to manage such investigations, and as a result the child was interviewed multiple times, resulting in lack of clarity regarding the child's statements.

Outcome: The investigation results were inconclusive, and unsupervised visits with the non-custodial parent were continued. Professionals involved with the child believed the child may be at risk due to the flawed nature of the investigation. CPS acknowledged its error, stating that it was participating on a multidisciplinary committee set up to revise the local sexual abuse investigation protocol to prevent such errors in the future.

Finding: CPS failed to document a referral alleging physical abuse of four non-dependent children, ages five to ten. CPS appropriately referred the caller to law enforcement for an immediate response, as these children were about to return to their custodial parent (the alleged perpetrator) out-of-state, and could be taken into protective custody immediately by the police if needed. However, it was a violation of law and policy for the referral not to be documented in the Children's Administration's computerized records and referred to CPS and law enforcement in the children's home state.

Outcome: The Ombudsman verified with a CPS Central Intake trainer that this referral should have been documented and referred to CPS in the children's home state. The trainer noted this as a training gap to be addressed in future CPS intake training.

COMPLAINT ISSUE: CHILD SAFETY FROM NEGLECT

Finding: CPS failed to investigate a referral alleging neglect of a toddler. The referral had been made by law enforcement, after an officer found a nineteen-month-old child at home alone. The officer had been able to locate the other parent, who returned home. CPS reduced the risk tag assigned to the referral (thereby eliminating the obligation to investigate it) due to law enforcement's involvement and high CPS workloads at the time.

Outcome: The Ombudsman brought this to the attention of CPS, which acknowledged that the referral should have been investigated. The Ombudsman monitored that office while staffing changes were made and caseloads reduced to prevent similar errors in the future.

COMPLAINT ISSUE: HEALTH, WELL-BEING OR PERMANENCY OF DEPENDENT CHILDREN

Finding: CWS compelled a local school district to dismiss an individual serving as the "surrogate parent" for a thirteen-year-old dependent youth. This individual had been appointed in accordance with state and federal education law, in order to advocate on the youth's behalf for an appropriate Individualized Education Program (IEP). CWS instructed the school district that the youth's CWS worker would replace this individual. The worker then attended an IEP meeting and signed the youth's IEP as the child's guardian. The Ombudsman found this to be in violation of education law which specifies that employees of school districts or public agencies responsible for the child's education or care are specifically excluded from being appointed as a "surrogate parent". The youth was temporarily left without an appointed "surrogate parent" to advocate on his behalf.

Outcome: The youth's foster parent was later appointed as "surrogate parent". The Ombudsman discussed the incident with the supervisor who acknowledged concerns of possible conflict of interest and agreed to provide training for workers regarding education law.

Finding: CWS informed a ten-year-old legally free child that a relative was considering adopting him, even though the relative had not yet reached a decision and had been told that the child would not be informed of this possibility. This action was unreasonable given that the child had a diagnosis of Reactive Attachment Disorder, increasing the potential that the child would experience feelings of rejection and abandonment if the adoption did not materialize (which it did not).

Preventing Future Mistakes *(continued)*

Outcome: The Ombudsman informed CWS of this finding. CWS acknowledged that this discussion should not have occurred.

Finding: CWS failed to consider the foster family for adoption of an almost two-year-old dependent child, though she had been cared for by them since the age of three months. The agency did not arrange an adoption home study and instead placed the child, along with her siblings, in a different foster home with the intention of having all the children adopted by those foster parents. The child was subsequently moved four more times.

Outcome: Although this complaint was received after-the-fact, as a result of concerns raised by the Ombudsman regarding placement committee procedures in the DCFS office involved, several revised procedures were implemented for future cases in which the child's current foster family wants to adopt the child.

Finding: CWS failed to thoroughly consider an out-of-state relative for placement of a dependent seven-month-old infant. The relative had already adopted the infant's four older siblings, yet the agency did not obtain a home study on the relative, and decided to allow the child to be adopted by her foster parents. CWS also failed to communicate effectively and in a timely manner with the out-of-state agency responsible for the siblings' placement.

Outcome: The Ombudsman requested that CWS fairly consider the relatives, but the agency declined to change its position. Based on the handling of this and other adoption cases in that CWS unit, the Regional Administrator made staffing changes in the unit and implemented new policies for more effective and fair management of adoptive placement decisions.

COMPLAINT ISSUE: PARENTS' RIGHTS

Finding: CWS failed to provide court-ordered visitation between a parent and a dependent 12-year-old child, failed to provide a report to the court on the child's progress and case plan, and failed to notify the parent's attorney of a court hearing.

Outcome: The court sanctioned CWS on all three violations, and visitation was subsequently provided as court-ordered. This court-ordered remedy had already occurred when the Ombudsman received a complaint regarding a different aspect of this case. However, the Ombudsman noted the agency's violations.

Finding: CPS refused to discuss a proposed safety plan with a parent undergoing a CPS investigation, during a telephone conference call with the parent and the parent's attorney. While the Ombudsman did not find this action to be clearly unreasonable, better practice would certainly involve the parent's attorney in such a discussion.

Outcome: The need for training for caseworkers on their legal duties to protect the constitutional and statutory rights of children and parents was addressed by the Legislature through the passing of a new bill to require such training for CPS caseworkers (SSB 5922).

Finding: DCFS erroneously provided a birth parent with confidential information regarding an adoptive parent, in agency records provided to the birth parent in response to her request for public disclosure. Agency staff failed to redact the adoptive parent's contact information when preparing the requested records.

Outcome: The region in which this breach of confidentiality occurred changed its administrative procedures to require supervisors to redact records provided through public disclosure requests (rather than administrative staff, as had previously been the case), and to keep copies of what records were provided.

COMPLAINT ISSUE: SERVICES TO RELATIVES

Finding: CPS led the relative caregivers of a dependent child to believe that the agency would be able to assist the relative in making capital improvements to their home in order to better accommodate the child. Financial assistance to foster parents and relative caregivers for capital improvements is expressly prohibited by law.

Outcome: The Ombudsman discussed these findings with the case supervisor and the Regional Administrator, who educated both agency staff and the relative regarding what kinds of assistance may be provided to caregivers for dependent children.

Preventing Future Mistakes *(continued)*

COMPLAINT ISSUE: FOSTER PARENT ISSUES

Finding: DLR/CPS failed to complete an investigation of alleged neglect and sexual abuse of a foster child by a foster parent, in a timely manner. The investigation was not concluded until eight months after the referral had been received, well after timelines for investigations required by agency policy. Although the findings of the investigation were "unfounded", the delay in reaching this finding was stressful for the foster parent as well as the child, who had been placed in a different home pending the outcome of the investigation. In addition, OFCL failed to follow proper procedures in investigating an earlier licensing complaint regarding the foster parent. The foster parent was neither informed about the complaint, nor given an opportunity to respond, and was not notified of the agency's finding of "valid" regarding the complaint.

Outcome: The Ombudsman contacted the statewide administrator for DLR expressing concerns about these violations of policy. The administrator agreed with the Ombudsman's findings and undertook to follow up with the supervisor in this case to prevent such violations in future.

Finding: CWS violated law and policy regarding confidential information, by disclosing the location of a child's foster home to the child's parents. This breach of confidentiality resulted in the child having to be moved to another foster home, and had negative consequences for the foster parents, who were followed by a registered sex offender known to the child's parents.

Outcome: The Ombudsman verified that the agency was conducting an internal investigation and taking appropriate action in response to a complaint made by the foster parent to the Regional Administrator.

Finding: DLR/CPS failed to complete an investigation in a timely manner, into alleged sexual abuse of two six-year-old foster children by the biological child of a foster parent. The alleged child perpetrator was not interviewed until eight months after the referral was received, and the investigation was not completed until a year after the referral, well after the ninety-day timeline required by policy.

Outcome: The Ombudsman received this complaint after the investigation was completed, but found that the delay in investigating not only compromised the integrity of the investigation, but also was very stressful for the foster family, who were unable to have foster children until the investigation was completed. The findings were "unfounded".